Patient/Family Information

Date ____________

Marital Status

Patient Name ____Age ______ Birthdate___________ S M D W

Gender: M/F/Non-Binary Identifies As: M/F/Non-Binary Preferred Pronoun(s) if applicable ____________

Address ____City ________________________State_____Zip________

Primary Contact Person ______________________________________ Relationship to Patient ____________________

Do you have dental insurance with orthodontic coverage? ☐ Yes ☐ No

Confidential Responsible Party/ Billing Party Information

Responsible Party ____ Relationship to Patient ____________________

Social Security Number ____________________________________ Date of Birth ______________________________

Address ____City _______________________State______Zip_______

How many years have you been at this address? ___________________________ ☐ Own ☐ Rent

Home Phone ____________________ Cell Phone ____________________

Work Phone ____________________ Extension _________ Email ____

Employer _________________________________Occupation _____________________# of yrs. Employed __________

Spouse's Name ____Relationship to Patient _______________________

Spouse's Social Security Number ____________________________ Date of Birth _______________________________

Spouse's Contact Numbers Cell Phone ______________________Work Phone _______________________________

***I UNDERSTAND THAT ALL INFORMATION ABOVE MUST BE FILLED OUT COMPLETELY AND MAY BE USED FOR CREDIT REFERENCE.**

____ _____________________

Signature **Date**

Are there situations that we should know about (divorce etc.)? ☐ **Yes** ☐ **No**

PLEASE EXPLAIN IF MARKED YES ____

With whom does the patient live? ☐ **Both Parents** ☐ **Mother** ☐ **Father** **Other** __________

OTHER CHILDREN/SIBLINGS

Name ____ Age _______ Date of Birth ____________________

Name ____ Age _______ Date of Birth ____________________